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ABSTRACT

A content analysis examined the narratives of 3,868 patients at 6 health care institutions, who described critical incidents during hospitalization and ambulatory health care. Results indicated that from the patient perspective, assessments of quality have less to do with clinical and administrative quality, than with providers' communication competency, and what is termed "relationship" quality. Findings suggest that patients in a variety of health care settings place a high premium on personal treatment, interpersonal communication, and relationships in forming their assessments of a health care institution and its staff. These issues warrent further examination. (Seven tables are included; 26 references are attached.) (PRA)

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STORIES PATIENTS TELL:

THE ROLE OF INTERPERSONAL COMMUNICATION IN PATIENTS' NARRATIVES ON MEMORABLE HEALTH CARE ENCOUNTERS AND EXPERIENCES

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A number of studies have documented that there is widespread public dissatisfaction with the quality of health care in the United States. Efforts to address the issue of quality of care have traditionally focused on matters related to *clinical/technical* quality. Health care organizations are also examining questions of *administrative* quality, and factors related to management practice and procedure. Research reported in this paper suggests that from the patient perspective, assessments of quality have less to do with clinical and administrative quality, than with providers' communication competency, and what is termed *relationship* quality. Presented is a content analysis of patient narratives of critical incidents during their hospitalization and as recipient of ambulatory health care services. The paper summarizes studies of nearly 4000 patients at 6 health care institutions.

DIMENSIONS OF QUALITY OF CARE: CLINICAL, ADMINISTRATIVE, RELATIONSHIP

A 1989 Harris Poll, indicated that nearly 90% of the U.S. citizens believe our health-care system needs a major overhaul (USA Today, May 25, 1989). There is little question that growing discontent regarding the health care, health care personnel, and our health care systems in general is widespread, and detractors are becoming increasingly visible and vocal.

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A number factors have contributed to the present circumstance, among them

- Cost Pressures
- More Demanding Consumers
- Capital and Labor Shortages
- Increasing Competition
- Rapid Technological Change
- Threat of Litigation
- New Diseases (e.g. AIDS, substance abuse)

In analyzing the challenges facing healthcare providers, primary attention is focused on clinical/technical quality of care, and increasing efforts to gather, quantify, and analyze information on clinical outcomes are being undertaken. The largest project of this kind is sponsored by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and involves about 400 hospital (McCormick, 190, p. 34). There are many other substantial initiatives in this area. The Humana group, for example, collects and analyzes data from each of its member hospitals relative to claims, readmission rates, infection rates, complication rates, and length of stay, for 14 clinical departments. System-wide profiles are then fed back to the individual institution as a baseline for quality assessment (McCormick, 190, p. 35).

More recently, emphasis is also being directed toward questions of administrative quality - matters related to management procedure and policy. Attesting to the growing interest in administrative quality is the emergence of programs such as Phillip Crosby Associates, Inc., Quality Improvement Process (QIP) and 3M's Total Quality Management (TQM) both of which apply quality assurance methodologies from other industries to the healthcare field.

As central as clinical/medical and administrative practices are to the quality of health care, it appears that much of the discontent with the quality of health care has less to do with clinical or administrative quality, than it does with what might be termed relationship quality.

Much can be learned about the nature of relationship quality from patients themselves, and not surprisingly a number of researchers have emphasized the patient perspective in their work (e.g. Bertakis, 1977; Ellmer & Olbrisch, 1983; Greenfield, Kaplan & Ware, 1985, 1986; Kaplan, Greenfield & Ware, 1989; Leebov, 1988; Pascoe, 1983; Ruben, 1985; Ware & Davies, 1983; Waitzkin, 1984, 1986)

METHOD

This paper reports on patient-centered research involving content analysis of patient narratives of critical incidents during their hospitalization or use of ambulatory health care facilities. The research involves 3868 patients at 6 hospitals and health services.[1] In essence, the method involves surveying patients subsequent to the hospitalization (or use of an ambulatory health care facility), and asking them to recall and recount their most memorable experience. In part, the survey utilizes the critical incident technique (Flanagan, 1954). This method is particularly useful as a means of accessing patient's constructions of their health care experiences via narrative story-telling. It allows for the emergence - rather than the imposition of - an

evaluative schema, and focuses on the events and dimensions of the patient experience which are most salient, memorable, and most likely to be retold.

Specifically, respondents were asked to:

> "Think back to your stay at the hospital (or visit to the health center) and describe, in a sentence or two, your most memorable positive or negative experience. (This can be any experience related to the hospital (or center), its staff or services)."

During a pilot testing phase, open-ended responses were analyzed, and six recurrent, discernible response themes were identified:

"Most memorable experiences related to . . ."

1. Clinical/technical facets of the treatment (abbreviated as: clinical);
2. The institutions policies and procedures (abbreviated as: policies);
3. The institutions facilities/accommodations (abbreviated as: facilities);
4. Aspects of their treatment relating to personal treatment and/or interpersonal communication (abbreviated as: interpersonal);
5. The quality and/or quantity of information provided (abbreviated as: information;
6. Other (abbreviated as: other).

Narratives were content-analyzed based on these response categories, relative frequencies, percentages, and relative rankings were calculated for each of the 6 institutions.

FINDINGS

As is apparent from Table 1, in each case, patients most memorable experiences more frequently involved the quality of their relationships with caregivers - and the way they were treated interpersonally - than circumstances related to either a clinical or administrative quality (Ruben, 1990a, 1990b; Ruben & Bowman, 1986; Ruben, Christensen & Guttman, 1990; B. Ruben & J. Ruben, 1987, 1988).

In 5 of the 6 populations studied, the "Clinical/Technical" category ranks second; in the case of the ambulatory healthcare center, the rank is third. Overall, "clinical" aspects of care account for only 27.0% (304/1125) of remembered experiences. Health care facilities - which included food in the case of the hospitals - is even less significant to the more lasting memories of health care. "Facilities" ranked fourth overall, accounting for only 7.3% (82/1125) of the experiences reported.

Table 1

Factors Associated with Patients' Most Memorable Experiences at Six Health Care Institutions

	Acute Care Hospital[1] 582 Bed-Community (N = 204)	Acute Care Hospital[2] 206 Bed-Urban (N = 96)	Acute Care Hospital[3] 248 Bed-Suburban (N = 286)	Acute Care Hospital[4] 354-Bed Community (N = 217)	Rehab Hospital[5] 88 Bed-Regional (N = 94)	Ambulatory Care Center-University[6] 84,867 Visits (N = 228)	Combined Data - Six Institutions (N = 1125)
Rank Order	*Factor / Percent*	*Factor / Percent*	*Factor / Percent*	*Factor / Percent*	*Factor / Perecent*	*Factor / Perecent*	*Factor / Perecent*
First	Interpersonal 39.2%	Interpersonal 47.9%	Interpersonal 46.3%	Interpersonal 58.5%	Interpersonal 56.4%	Interpersonal 37.7%	Interpersonal 46.7%
Second	Clinical 34.8%	Clinical 25.0%	Clinical 33.2%	Clinical 24.9%	Clinical 19.2%	Policies 22.4%	Clinical 27.0%
Third	Information 6.9%	Facilities 12.5%	Information 10.1%	Facilities 6.5%	Facilities 18.1%	Clinical 18.4%	Policies 9.4%
Fourth	Other 6.9%	Policies 9.4%	Policies 5.2%	Policies 6.0%	Policies 5.3%	Information 11.8%	Facilities 7.3%
Fifth	Policies 6.4%	Other 4.2%	Facilities 3.2%	Information 3.7%	Other 1.1%	Other 7.9%	Information 5.8%
Sixth	Facilities 5.9%	Information 1.0	Other 1.8	Other .5%	Information 0%	Facilities 1.8%	Other 3.9%

[1]Reported in B. Ruben, Zakahi & Kreps, (1985). [2]Reported in B. Ruben & J. Ruben (1988). [3]Reported in Ruben (1990); Ruben & Bowman (1987); Ruben (1986). [4]Reported in B. Ruben, 1987. [5]Reported in B. Ruben & J. Ruben (1987). [6]Reported in Ruben (1990); Ruben, Christensen & Guttman (1990).

First, by a substantial margin for all for healthcare institutions, is personal treatment and interpersonal communication. Across the six populations, "Interpersonal" accounts for 46.7% (525/1125) of all responses. "Policies and Procedures" accounts for 9.4% of the responses overall. "Quality/Quantity of Information Provided" ranked fifth at 5.8%, and "Other" – which included factors like cost and convenience – ranked sixths at 3.9%.

It can be argued that both "Quality/Quantity of Information Provided" and "Personal Treatment/Interpersonal Communication" are facets of communication. If these two categories were combined the primary role of relationship quality is emphasized even more dramatically. Tables 2 - 7 provide examples of the patient responses in each category.

Table 2
Patients' Most Memorable Experiences:
Representative Responses

Personal Treatment/Interpersonal Communication

Positive Statements:

"Seeing physician... I was very nervous but she made me feel calm. Made me feel comfortable."

"The staff gave me the impression that they were interested in me as a person rather than just in doing a job of taking care of me."

"All physicians are nice . . . . They seem to care."

"Without exception, every nurse on the floor took care of my father as if he were their father."

"The most pleasant experience was that most of the people treated me very well."

"The friendly attitude makes you feel relaxed when you are tense."

"I have the highest regard for nurses and staff in the maternity ward. They left me with a positive attitude toward birth."

Negative Statements:

"Need more attentive and listening doctors and nurses."

"Many technicians, in my opinion, lacked compassion and concern. They also had no respect for my dignity or modesty. A friendly smile would have helped. They did what they were trained to do and that's all."

"Nurses discuss each patient openly to other nurses, affording anyone in a nearby room an ear-full."

"Being a new mother, I needed instruction, not criticism."

"Please let us feel like we're human."

"Elderly patients are treated like garbage."

"The guards and the receptionists were very impolite with my family and myself."

"Many Black nurses treated Black patients better that Whites."

Table 3
Patients' Most Memorable Experiences:
Representative Responses

Clinical/Technical

Positive Statements:

"Got better fast. Identified problem and gave medicine quickly."

"I was very happy with the services rendered in the Emergency Room. I was admitted and treated quickly."

"Blood test didn't hurt at all."

"The help of the nurses in the maternity ward . . . knew when to help me and when to let me do things on my own."

"They really take time. You're not rushed through."

Negative Statements:

"A female doctor was looking to give me an intravenous without checking my name or room number. She had wrong room, wrong sex."

"I was very unhappy because I had to wait three days for a plastic surgeon for a cut on my lip."

"They don't know what they're doing... couldn't find vein."

"The RN almost gave my infection medicine to my roommate who was very allergic to it."

"They never x-rayed anything. Just said it was a sprain."

Table 4
Patients' Most Memorable Experiences:
Representative Responses

Policies/Procedures

Positive Statements:

"They let you walk in. You don't need an appointment."

"I was impressed by the lack of waiting."

"Attentions given to siblings of newborn is a nice touch."

Negative Statements:

"Too much paperwork... too confusing when you first walk in. You don't know where to go or what to do."

"I was told to come back Monday for a blood test, because they don't do blood tests after 12:00. It was very annoying."

"The admissions testing should all be done on one floor."

"Mental patients should not be allowed on floors with other patients."

"Waiting time is too long. Waited two hours for a shot."

Table 5
Patients' Most Memorable Experiences:
Representative Responses

Facilities/Accommodations

Positive Statements:

"The birthing room facilities were peaceful and beautiful."

"I have gone to college previously in New York State. The health service building here is much better than what I am used to."

"I loved having my own shower in my room."

Negative Statements:

"The ER is very dirty."

"Get a nicer waiting area. Chairs are uncomfortable."

"Noisy children are unattended and drunken adults bother the patients."

"Smoke from the nurses lounges was very unpleasant."

Table 6
Patients' Most Memorable Experiences:
Representative Responses

Quality/Quantity of Information Provided
Positive Statements:
"The night before my operation the doctor explained the operation to me. This relaxed me."
"The physician explained everything in detail."
"A staff member told me how she reduces stress . . . was friendly."
"When you need to buy a product at the pharmacy, they are never too busy to give you recommendations."
Negative Statements:
"Doctors should tell patients results of tests, and give more information about patient's illness."
"The emergency room should keep you informed as to why you are lying there for so long.
"The doctor didn't tell me he was going on vacation, so no one knew who was suppose to take out my stitches."
"Wish they could better explain about blood test results."

Table 7
Patients' Most Memorable Experiences:
Representative Responses

Other (General Statements, Convenience, Cost)
Positive Statements:
"Everything very nice."
"Came away with positive impression."
"Convenient."
Negative Statements:
"Would go (to another facility) if I could wait."

DISCUSSION

These results do not address the issue of how patients were actually cared for. Their value is as a description of how patients perceived they were treated, and perhaps more interestingly, about the criteria they used in evaluating the quality of care they received. By implication, the study also provides useful insights as to probable sources of satisfaction and dissatisfaction among patients, and helps to explain the basis upon which images of health services are formed.

The findings from these project argue persuasively that patients in a variety of healthcare settings place a very high premium on personal treatment, interpersonal communication, and relationships in forming their impressions of a health care institution and its staff.

As can be discerned from the sampling of patient responses, the research also indicates that all staff play a vital role in creating the experiences which are most critical and memorable to patients. Nurses, nurse practitioners, receptionists, and other staff, as well as physicians, are mentioned in patient's comments. For instance, in the case of the ambulatory care facility (Ruben, 1990; Ruben, Christensen & Guttman, 1990), nurses and nurse practitioners were most often mentioned. They were referred to in 34.3% of the narratives on memorable experiences, and generally in a positive context (60.6% positive vs. 39.4% negative). Physicians were mentioned in 29.2% of the recounted scenarios (64.3% positive vs. 35.7% negative). Receptionists and other non-technical staff were recalled in 26% of the noted experiences, with a majority (56.0% vs. 44.0%) positive.

Again, it is important to remember that these results refer to patient perceptions. However, it is equally important to note the many reasons why the patient's perspective and relationship quality are important. Beyond contributing to a patient's satisfaction or dissatisfaction with health care systems in general, relationship quality impacts upon patient compliance and the course of treatment. It also forms the basis for the reputation and image of individual staff members and health center as an organization, influences the probability of malpractice litigation, and facilitates or impedes the appropriate utilization of health care facilities.

IMPLICATIONS: BARRIERS TO RELATIONSHIP QUALITY

At the heart of the linkage between communication and health care is the interpersonal communication between caregivers and patients, and the nature of the relationship which evolves therefrom. Unfortunately caregiver-patient communication and relationships are as problematic as they are important, embodying all the complexity and challenge – and even greater stress – than is present in other professional-lay encounters.

As with the teacher and student, the attorney and client, or the librarian and the information seeker, the relationship between the caregiver and the patient is characteristically asymmetrical, in that expertise and power are unevenly distributed. And while both parties to such relationships can be said to have a common purpose, they seldom share common perspectives.

For their part, physicians, nurses, lab techs, receptionists, administrators, and other staff come to encounters as knowledgeable professionals, "at home" in the environment in which the

interactions are occurring, seeing patients on a schedule which they set. Factors such as time pressures, job stress, the burden of paperwork, threat of malpractice, difficult patients, interpersonal stress and problems of coordination and repetition present barriers for the caregiver. Nonetheless, caregivers are familiar with terminology and protocols, comfortable with the tasks at hand (medical histories, physical exams and diagnostic procedures), and generally equipped with substantial experience regarding the range of medical problems and circumstances which present themselves.

Healthcare providers make their judgments of the quality of care using clinical and technical criteria – Have correct diagnostic procedures been followed? Were appropriate treatment protocols adhered to? Was testing conducted in a technically correct manner? (Droste, 1988; Siegel, 1986; 1990; Steiber, 1988)

In contrast, patients come to the relationship "looking for help" in some form. They do so in an environment that is unfamiliar - one which they often perceive as intimidating. Patients must schedule the encounter at the convenience of the caregivers, and often have to wait to be seen. Frequently they enter the interaction anxious about their health, and lacking medical knowledge or relevant professional expertise. For the patient, even "routine" history-taking, physical exams, and tests are often uncomfortable, because they call for levels of verbal disclosure and physical contact normally reserved for intimate relationships. And, depending upon the outcome of these encounters, patients may be faced with the need to comply with recommendations for behavioral change, undergo additional testing, or accept continuing uncertainty about their health status.

Caregivers make assessments of quality of care based on clinical and technical criteria, clinical and technical skills or competencies of providers, and the manner in which patients are treated medically. Since most patients and family members lack the knowledge necessary to assess the clinical quality of the care they receive, their evaluations emphasize relationship quality, the interpersonal communication skills and competencies of caregiver, and the manner in which they are treated personally. (Korsch, et al., 1972; Ruben, 1990;1986; Ruben & Ruben, 1988; Ruben, Christensen & Guttman, 1990, Steiber, 1988).

Over the course of a hospital stay or a visit to a physician's office, a patient is likely to have any number of encounters - each of which in subtle and not so subtle ways shapes the impressions which are formed of the quality of the health care givers, the organization, and by extension, the health care itself. If those encounters include a receptionist who seems to lack compassion, a physician who doesn't seem to be paying attention, or a nurse who seems to be impolite, the seeds of dissatisfaction are easily planted.

CONCLUSION

Given the potential range of incompatibilities in needs, goals, and perspectives it is not surprising that despite the best intentions by all parties, caregiver-patient encounters are frequently plagued by misunderstanding and mistrust:

- After weeks of pain and visits to several physicians, a patient has been referred to a "highly-regarded neurologist." The patient introduces herself and begins to describe

the problem. The neurologist explains that it isn't necessary to hear her symptoms, that the examination and test results will tell her everything she will need to know.

- A patient considering a vasectomy has a number of questions and concerns, and schedules a consultation visit with a urologist. When the patient asks about possible side effects or complications, the physician responds "There's really no evidence to suggest that there are negative side effects, but who knows. We thought Thalidamide was safe, too." The patient says that he has some concerns about the procedure. The physician hands him a pamphlet "which will answer all the questions," and tells him to call the receptionist to schedule the procedure if he decides to go ahead.

- A patient is waiting to be seen. He overhears a physician speaking angrily to a resident and a nurse about an "echo" that was conducted on the wrong patient.

- A patient who was previously operated on for breast cancer discovers several new lumps and a cough which her physician describes as "suspicious." She is sent to a nearby X-ray group for chest x-rays. The tests are completed, the woman is asked to return to the crowded waiting room while the pictures are developed. In ten minutes, the radiologist walks into the waiting room and announces loudly across the still-full waiting room that he has developed the X-rays, and has just spoken to the woman's physician . . . . The patient is to take the X-rays and go immediately to the Emergency room of the hospital to meet her physician.

From the patient point of view, each of these situations[2] is a critical incident from the perspective of relationship quality. In each, there is a loss . . . of confidence, trust, information, of the potential for quality health care. This occurs not for the lack of good intention, nor of first-rate clinical skill, but rather for the lack of interpersonal communication skill.

Patient-generated critical incident narratives provide an important perspective on caregiver-patient encounters, and nature of health care experiences more generally. The research indicates that providers' interpersonal communication and relationship competencies are basic to patients' constructions, assessments, and reconstructions of their health care encounters. By implication, these findings also seem also to suggest that provider communication skills may play a fundamental role in patients' assessments of the quality of care they have received. Each of these important issues warrants further investigation.

NOTES

1. The research consisted of surveys of a total of 3,868 patients at six institutions in the Northeast:

    1. Acute Care Hospital (Community): Random sample - 1,000; returns - 253; response rate - 25.3%.
    2. Acute Care Hospital (Urban): Random sample - 381; returns - 96; response rate - 25.2%
    3. Acute Care Hospital (Community): Random sample - 1,000; returns - 226; response rate - 22.6%
    4. Acute Care Hospital (Suburban): Random sample 927; returns - 338; response rate - 36.5%
    5. Rehab Hospital (Regional): Total patient population was surveyed - 360; returns - 130; response rate - 36.1.
    6. Ambulatory Care Center (University) - random point of departure interviewer-aided surveys at three sites - 200; returns - 200; response rate - 100%.

2. Based on critical incident narratives provided in patient interviews.

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